MEDICAL SCHOOLS AS MORAL AGENTS[1, 2]

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While many aspects of medical practice have been subjected to ethical scrutiny in the past decade, medical education itself has not. Preparing for this talk, for example, I did a Medline search of 5092 postings on medical education, and 2285 on medical ethics and combinations thereof. I turned up not a single paper in the last ten years on the ethics *of* medical education. A similar search in the literature of Western Europe and in sociological abstracts was equally unproductive.

It is clear that formal analysis of the moral obligations of medical schools has been infrequently undertaken, if at all. There are some evident reasons for this neglect.

To begin with, physicians are currently feeling a bit surfeited with the close ethical scrutiny of medicine. The recent past has seen an unprecedented upsurge of interest in biomedical ethical issues. They have been debated in the public media as well as scholarly journals. So much has this been the case, that many physicians have developed emotional sensitivity to, and a reluctance for, such discussions.[3]

This sensitivity is reinforced by the deeply rooted positivism of medical education which has always cast doubt on the intellectual respectability of ethical discourse. Physicians, as a result, still regard ethical judgments as too subjective or relative to warrant reasoned critical analysis.

Then, medical education is a passionate subject, with too many of the attributes of an ideology. So, many of the claims for what medical schools are supposed to be doing in the interest of society or students are unprovable. The idea of ethical inquiry, therefore, seems particularly threatening.

Finally, ethicists are seen as the most recent in a long line of critics – consumers, politicos, lawyers, economists, and popular writers – all of whom have peered and poked at the most intimate details of the corpus medicum. The wholly essential and highly responsible examination of matters medical by professional ethicists has been somewhat obscured by the questionable knowledge and motivation of the popularizers.

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The Necessity for an Ethics of Medical Education

These impedances notwithstanding, there are some very good reasons for a vigorous examination of the moral purposes of medical schools and medical education. Indeed, a critical examination of the obligations of medical schools to those they serve is already seriously overdue.

We are, in America, engaged in a reappraisal – sometimes too cynically – of the value and purpose of all our social institutions. The recent deep concern for the ethics of biomedical decision making is part of that larger phenomenon.[4] Medical education cannot long exempt itself from this general climate of scrutiny.

Moreover, some of the questions have already been asked – albeit polemically and emotionally – in the campus and social unrest of the late sixties. That was not a time for formal or cogent analyses, but the purposes of medical education were questioned sufficiently openly to preclude a return to the unexamined positions so complacently held for most of the twentieth century. The questions are still just below the surface, despite the apparent calm on the educational scene today.

Medical schools, like other instruments of social purpose, are moral agents. Their decisions and actions involve value choices and affect the lives of all of us. Medical educators have too often neglected this fact, or at least have attended to it only implicitly or uncritically. They have in recent years leaned too heavily on political, ideological and economic justifications, rather than moral ones. Political solutions, while not to be discredited, cannot substitute for clear statements of moral obligation. They can only postpone the confrontations with the deeper moral issues upon which society will ultimately judge medical education.

There is a genuine need, therefore, despite the reluctance of physicians, to engage in ethical discourse, to reflect critically and dialectically on the assumptions and values we hold in medical education. Medical schools occupy a special position in society which is inconsistent with equivocal or untested assumptions about what is "good" for society, students and patients.

It is, moreover, a responsibility of professionals who wish to be educated men, to examine their own enterprises in terms which transcend self-interest. Physicians are not attuned to the adversarial climate which prevades today's society. They must accommodate to it, however, if they are to maintain their credibility. This demands a willingness to appraise critically, and rationally, all the positions they were formerly accustomed to taking in the "interest" of society.

The reasons for examining the subject outweigh its inherent difficulties and unpalatability. To initiate the kind of questioning I believe necessary, I will attempt to map out the domain to be examined. Only

three points in the topography of this domain can be located in the time available: first, the source of the special moral obligations of medical schools; second, the range of obligations which flow from this special social position; and third, the conflicts which may arise in fulfilling these obligations.

The Terms to be Used

The terms in which ethical discourse is carried out are troublesome and subject to various interpretations even among ethicists. It is mandatory, therefore, to provide some operational definitions which will delimit the sense in which the terms are used in this essay.

Ethics I understand as a branch of philosophy which systematically examines rightness of human conduct. *Classical normative ethics* placed its emphasis on human conduct itself and attempted to arrive at generalizable principles of right conduct, together with the rational justifications of those principles. *Modern ethics* places its emphasis on knowledge, not conduct per se; it is concerned, rather, with the meanings, usages and logic of moral statements, and it eschews recommendations about what is right human conduct.[5]

My concern will be with the more classical normative sense of ethics, and thus with obligations of medical schools generalizable from the nature of their social functions. While metaethical analyses of ethical terms and language are important, it will be secondary for our present purposes.

The ethics of medical education and of medical schools is a branch of ethics which is itself as yet largely unexplored. I refer to social ethics, the systematic inquiry into the actions of individuals and institutions which affect society or communities, as well as the special moral obligations which bind individuals when they act as members of a group, collectivity or institution. Institutions as well as individuals, in this sense, can be moral agents, and their acts, like those of individuals, are also subject to ethical judgment.

There is only scanty reference of the moral obligations of teachers to students or medical schools to their constituencies in the ethical codes of the profession. The first few lines of the Oath of Hippocrates do define the mutual obligations of student and teacher in essentially paternalistic terms. While innumerable medical writers over the centuries have alluded to the content and methodology of medical education, there are only the most indirect references to the moral responsibilities of medical schools as instruments of social and public purpose.

The Source of Moral Obligations

The ethical justification of any institution rests in the degree to which it matches its performance with the purposes for which society estab-

lishes and supports it. In this respect, medical schools stand in a very particular relationship to society, one which gives them unusual powers, and correspondingly weighty ethical obligations. Four facts about the social situation of medical school are fundamental to any derivation of their ethical obligations:

First, their triadic functions—teaching, advancing knowledge, and patient care—are all essential to the social welfare. Second, medical schools are the only means of access to the full knowledge of medical practice and, therefore, of entry into the profession. They effectively enjoy an undisputed monopoly. Third, they voluntarily accept public funds in return for serving the public interest. And fourth, they enjoy an exceptionally wide latitude of decision making in the performance of their functions.

Medical schools are accorded this privileged position simply because mankind is subject to illness that can be cured, contained or prevented by medical knowledge. The medical school has guardianship over that socially essential knowledge—its generation, preservation, transmission and advancement. While nursing, pharmacy, dental and other schools in the health professions also have guardianship of some parts of medical or other essential knowledge, only medical schools embrace the whole of what is essential to licensure and legal admittance to the practice of diagnosis and therapy of disease.

These four facts about the social situation of medical schools impose a set of obligations to the three major constitutencies whom they purport to serve—society in general, teachers and faculties, and patients treated under medical school auspices. Any inquiry properly labeled an ethics of medical education must define the obligations to each of these constituencies and establish some order between them when they are in conflict with each other.

Obligations to Society

At least four fundamental obligations are owed to society if a medical school is to justify the support it receives and the declaration it makes to serve public interests.

First, it must assure a continuous supply of medical personnel, adjusted in number and kind to perceived and actual needs of society. Second, its medical graduates must be safe and competent practitioners, and those who lack integrity must be denied the sanction of a medical degree. Third, equity of entry and thus access to the profession must be assured to all qualified segments of society. And, fourth, medical knowledge must be preserved, constantly validated, transmitted in teaching, and extended in research.

While these obligations are generally accepted by medical educators, they are not understood clearly as "moral" obligations which arise out of

the special position of medical schools in society. They are not obligations assumed by medical educators out of their benevolence. How well each of these functions is carried out must be examined not just in terms defined by the medical school, or consistent solely with its value system.

The kinds of moral questions which can justifiably be asked of medical schools about these four social obligations might go as follows:

First, as to the supply of medical manpower—Is this obligation morally fulfilled if medical schools leave the supply of physicians in number, kind and distribution to economic or political forces, or even to personal choice entirely?

Can medical schools claim to serve the public interest if the ratio of specialists and generalists they produce is seriously out of phase with public need?

Have medical schools extended themselves sufficiently in optimizing the probabilities that students will choose underserved locations and communities in which to practice?

What is the moral basis of the claim to academic freedom insofar as determining what kind of students shall be prepared? Are there social obligations which modulate, or even transcend, the important claim to academic autonomy? How much of this autonomy is yielded in the act of accepting public funds for public purposes?

In short, as the gateway to the profession, to licensure, and to the kind of physicians society will have available, does not the medical school incur obligations which need reappraisal in terms of social ethics? We may all have read answers to these questions, but what is at issue is the concordance of our answers with some larger conception of what we owe by virtue of our declaration to serve society.

A like set of questions can be raised about a medical school's *second* obligation to society to provide competent graduates who will practice with integrity and safety. After all, graduation from medical school, in this country at least, is tantamount to admission into practice. The failure rate is very low, and much of the detection of character or personality traits inimical to safety or competence devolves, in fact, upon the medical school, although the final sanction to practice is legal.

How well do the present patterns of instruction permit us to assess competence and integrity?

Is this responsibility consistent with the degree of contact we provide with experienced clinicians, or is too much left to intermittent superficial contacts or delegated to an already overworked house staff?

Do we need to allocate time, resources and personnel specifically to a closer evaluation of performance, judgment, humaneness in each student?

How prone are we to excuse lapses in competence or even integrity the further along a student is in his medical school career?

How can we morally balance the obligations of fairness to the student against the fact that we must judge his capacity to practice his art on other humans?

What about the *third* social obligation – equity of access to admission? As a principle, this is beyond debate in a democratic society.

How does this obligation square with the equally binding obligation to redress the imbalance of minority representation in the profession and the cumulative effects of past social injustice?

What about the justification for considering "attitudes" as criteria for admission of a more humanistic group of students? Are these criteria valid? Are they in the best interests of society?

Are the time, expense and results of our present, highly selective admissions systems morally defensible? Have we really defined the values which dominate our choices? What is the relationship of those values to the kinds of physicians society, in fact, needs?

Should consideration be given to a lottery system which would establish certain cut-off criteria and then select randomly among those with certain baseline qualifications? How would such a system square with the need to offer opportunities to specific segments of our population?

What is the moral responsibility of a medical school for the admittedly competetive atmosphere created in our universities by medical school admissions practices?

Again, medical schools have answers to these questions. The issue here is how well these answers have been, or could be, justified on the basis of the moral obligations of medical schools rather than their convictions of the rectitude of the current beliefs about what is "good" for medicine and the profession.

The *fourth* general social obligation of medical schools is to advance medical knowledge. Medical schools concentrate research, equipment and personnel, and provide the environment without which medical advances would be impossible. Research is not a social luxury, it is a necessity.

This is a statement to which acquiescence is only too easily obtained. The ethical dilemmas begin, however, when this obligation is placed against the other two main obligations of medical schools to society – to teach, and to provide patient care.

When these are in conflict as manifestly as they frequently are, which has priority? Is "good" research defensible by itself in the face of neglect of teaching, or inadequacies in care of patients. How much does this research obligation justify assignment of teaching or patient care to junior associates? When care of patients is involved, there can be no question of which priority comes first. Yet how often are these choices made without conscious reflection? One hears repeatedly, for example, that the university hospital exists primarily as a "teaching" laboratory

of the medical school. Is such a statement ever justifiable in any hospital, which must by its first commitment to society place care of patients first?

Here again, what is required is not a quick answer which resolves the dilemmas in terms of an unexamined ideology of "good" medical education or research. It is the essence of ethical discourse that when conflicts of obligations occur, some order of priority be made among them. This does not mean absolute rules of conduct for all cases, but concrete, particular decisions consciously made which place some things above others. If a medical school is to take the reality of its moral agency seriously, it is obliged to assure that this kind of critical ethical discourse occurs; otherwise, it is easy to slip into the dominance of one value system over another and to violate human rights for abstract ends.

Few things have more seriously eroded confidence in institutions than the public revelations of the value priorities which underlie their decision making. Medical schools are in too morally sensitive a social position to allow themselves to take the inevitable conflicts in their obligations lightly, or to resolve them by default.

Obligations to Students

The moral responsibility of a medical school to its major constituency – the students it purports to educate – would seem to be so obvious as to preclude discussion. Nevertheless, in this realm too, the ethical dimensions of faculty and administration have not been sufficiently rigorously or explicitly addressed.

This was a main focus for attack on schools in the emotional diatribes of the late 60's. "Relevance" was the cry then, as "dehumanization" is the cry now. This is not the place to analyze the cultural and social anthropology of medical schools or faculty-student relationships. The nature of the moral questions, however, is illustrable by allusion to only one facet of this relationship – the quality of teaching.

The shift in shibboleths from "relevance" to "dehumanization" must not obscure a perennial complaint among students – and this includes university students as well – the quality of teaching. A sophisticated ethical disquisition is not needed to apprehend the moral requirement of a medical school to provide quality in teaching, unless we are willing to admit its irrelevance for student thought, behavior and performance, or his present capacity to learn.

The obviousness of this obligation is in no way correlated with the degree to which it is fulfilled. Poor preparation, poor delivery, riding personal research hobby horses, bad-mouthing other disciplines, failing to meet classes, relegating teaching to house staff, language barriers,

needless repetition, sermonizing – the whole hoary litany of pedagogical perversities – is too easy to recite. Their persistence is not so much a matter of failure to understand the principles of education, as a failure in the primary moral obligation of teachers to students.

As tuitions climb to $10,000 per year or more, the basic business ethics of "getting one's money's worth" may prevail where loftier ideals of responsible pedagogy have not. Whether or not this becomes the case, the quality of teaching is unavoidably a corporate as well as an individual ethical obligation for everyone associated with a medical school. Poor teachers must be detected and their difficulties diagnosed; they must be rehabilitated, reassigned, or if that is not possible, removed. Research stature and productivity do not excuse poor performance in the classroom. This is *not* the same as saying that research activity is unimportant for good pedagogy.

The point need not be labored further. The moral sensibilities of a medical school are revealed in its provisions for adequate teaching facilities, for student health and counseling, for assisting in the personal and emotional crises of student adaptation to death, dying and the cadaver, and for student input in the evaluation of teaching and teachers. In this realm student assessments have considerable, though not exclusive, authority.

There will be a conflict even with these obvious obligations. The faculty has certain rights as well as students. "Academic freedom" in its intellectual rather than its political sense, is to be respected. Yet this principle can be invoked inappropriately to protect poor teaching from institutional surveillance. What are the limits of academic freedom, and how is it proportioned to the equally demanding obligation to provide quality teaching?

As in responding to the obligations to society, it is the ready answer, the ideological stance and the self-justifying position which must be distrusted. The moral agency of medical schools unavoidably propels them into moral conflict. Only genuinely sound and critical moral discourse can provide rationally justifiable resolutions.

Obligations to Patients

The medical school and medical centers are almost unique among educational institutions. They must satisfy the obligations to teach and to do research. But as a necessary part of those efforts, they must also care for patients. As patient care institutions, medical centers cannot place their care responsibility in any secondary position. The patient in a university owned and operated hospital is owed the same obligations due patients in any other hospital. When patients' needs are in obvious

conflict with the other responsibilities to educate health personnel or advance knowledge, the needs of patients must predominate.

Society permits a measure of prudent, limited, and unavoidable intrusion on the ordinary obligations owed to all patients, if they are in a teaching hospital. Only by increasing responsibility under supervision can the next generation of physicians and other health workers be adequately prepared. Nonetheless, it must never be forgotten that they are learning as they provide services. Those services are, then, to some degree more time-consuming, more often duplicated, more uncomfortable, and occasionally more dangerous than if they were performed by fully experienced practitioners.

Society, students and residents are the beneficiaries of the social mandate which acknowledged teaching and research as complementary to patient care in teaching hospitals. But this mandate also imposes special moral obligations on medical schools whose faculties are responsible for clinical supervision. The safeguards must be meticulously attended to, not only for the safety of the patient, but also since the teaching hospital is the most powerful molder of the value systems of its students and residents.

The patients should know they are in a teaching institution; they should also know the identity of those who care for them – who is a student, who a resident, fellow or attending; and who may be carrying out procedures. The privilege of refusing to participate in certain teaching functions must be preserved. Supervision by experienced faculty clinicians should be a fact – not just a promise. While the rights to consent and disclosure are monitored in human investigations, they are less rigorously guarded in the matter of the patient's participation as a subject of clinical teaching.

Here too, as in the two domains of its moral agency already mentioned, the medical school faces conflicts of obligations. For example, how do the obligations to patients qua patients square with the boast – this is a resident's hospital"? Such an assertion is a potent recruiting device, and usually means the residents are in full control of patient care with minimal "interference" from attending staff. Granting the value of such an arrangement for resident instruction, and even the frequent superiority of a resident's technical information, is it consistent with optimal care of patients?

At times, students and residents may regard access to patients as their right or, more reprehensibly, as the price exacted from the poor for care they cannot otherwise afford. It is a little too easy to regard all the works of a medical school as inherently "good" for the future of society, and thus to obliterate insensitivities to the more immediate obligations owed to patients. The medical school-teaching hospital is still a hospital

first. Confusion on this point is not socially tolerable, and can only lead to constraints on both teaching and research. Hospitals themselves act as moral agents, as I have developed elsewhere, and so we can encounter in medical school-hospital relationships the conflict of obligations of two moral agents.

Institutional and Individual Moral Agents

Every faculty member, student, trustee, administrator in a medical school is also a moral agent – in two senses, at least. First, each bears a moral responsibility for his/her personal behavior in respect to the obligations of medical schools, and secondly a responsibility for the collective actions of policies of the school with respect to its obligations as an institution in society. The degree of those responsibilities for collective action varies, of course – faculty trustees and administration bearing a more explicit burden than students, but none are totally exempt.

There are times when the moral agency of the individual and that of the institution come into conflict. This conflict is a subset of the larger issue of personal moral responsibility for the actions of any collectivity of which we are a part, whether as citizens of a country, employees of a corporation, members of a health care team, or members of a church. The resolution of conflicts between the opposing obligations of one moral agency and another is a complex domain of ethics still very much unexplored. The medical school is only one arena for these conflicts, but one which is in a specially sensitive position and therefore compelled to a more conscious explication of its obligations than has been customary.

It may be some time in coming, but the possibility of a more explicit code of ethical obligations for medical schools should be entertained. The situation is far more complex than it was in Hippocratic times. The simple pedagogic paternalism of the opening sentences of the Oath[6] will not suffice in our times, when every social agency can expect to come under even closer scrutiny in the years ahead.

Recapitulation

This essay is not in any way a definitive explication of the ethics of medical education. Its purpose is simply to underscore the fact that, like it or not, the medical school exercises a moral agency; that this moral agency derives from the medical school's special location in society and the obligations it incurs to society as a whole, to students and patients; and that a more explicit, formal and rational justification of those obligations is overdue. Instead of economic, political or ideological justifications, medical educators need to ground their actions more firmly on ethical principles. Ethical discourse is therefore a proper and essential

feature of both the practical and pedagogic responsibilities of medical schools.

NOTES

1. The subject of this paper is more fully and more explicitly considered in a forthcoming article in the *Encyclopedia of Bioethics*, The Free Press, A Division of MacMillan Publishing Co., Inc.—E. D. Pellegrino, "The Philosophy and Ethics of Medical Education."
2. The idea of moral agency is extended to hospitals in my Harvey Weiss Lecture, unpublished, ("Hospitals as Moral Agents") and in my commentary on Alisdair MacIntyre's paper "Patients as Agents" ("Moral Agency and Professional Ethics: Some Notes on Transformation of the Physician-Patient Encounter"), to be published in Philosophical Medical Ethics: Its Nature and Significance, Vol. III of Philosophy & Medicine (Stuart Spicker and H. T. Engelhardt, Eds.) Dordrecht, Holland: Reidel Publishers, 1977.
3. See Danner Clouser's article "Medical Ethics: Some Uses, Abuses and Limitations." *New England Journal of Medicine* 293 (August 1975): 384-387.
4. See Renee Fox, "Ethical and Existential Developments in Contemporaneous American Medicine: Their Implications for Culture and Society," *Milbank Memorial Fund Quarterly* (Fall 1974), pp. 445-483. This paper by an eminent sociologist shows how the interest in bioethics reflects a much larger social concern of Americans.
5. For a full explication of the differences between classical and modern ethical systems and theories, see the very complete article by Raziel Abelson and Kai Nielsen, titled "The History of Ethics," *The Encyclopedia of Philosophy*, Paul Edwards (ed.), Vol. III, pp. 81-117, 1967.
6. For the text of the Oath and a most authoritative and complete commentary on its socio-historical significance, see Ludwig Edelstein, The Hippocratic Oath: Text, Translation and Interpretation, Supplement to the *Bulletin of the History of Medicine*, No. 1, Baltimore: The Johns Hopkins Press, 1941.

DISCUSSION

DR. THOMAS N. JAMES (Birmingham): Most democratic societies regulate themselves by a system of laws, and the law is certainly one of the major professions. I once had a tennis partner who reminded me that medicine was surely going to be regulated by the public, because the public is determined to regulate anything it doesn't understand. I wonder if you would speak about the special dilemma which lawyers face in being legislators too. They will be responsible for the laws to regulate all professions including our own.

DR. PELLEGRINO: Your comment is correct, I believe. Most legislators are lawyers. Society must raise the very same questions about the legal, and indeed every other, profession. You are right—if we are to question others, we must first scrutinize ourselves. This is what I have called for with respect to medical education, and elsewhere with respect to the need for an expanded medical ethics more adequate to the issues we face today.

You referred to the fact that many issues are now settled in law. I think this is somewhat unfortunate and a reflection on our own lack of ethical sensitivities—particularly with respect to our social obligations. This does not mean we must vacillate with every change in public whim and fancy. It does mean a more critical reflection on the behavior of our own profession first. Before exercising ourselves because other professions may be just as insensitive, we ought to inquire into the reality of the criticisms now leveled at medicine.

DR. THOMAS N. HUNTER (Charlottesville): It seems to me that one of our greatest troubles in this very important area that you talk about is the sudden change in the expectations of society of medical schools. Suddenly we have been charged with solving almost all of what our society views as its health problems. I think the pendulum has swung so far that many social problems over which that we have no control, such as those alluded to by Stewart, are viewed as our responsibility. We have some influence but we certainly don't control these total environmental forces. Let me say that I hope – again being hortatory – that we can manage to define more clearly what we really believe to be the proper social responsibilities of medical schools. Until we do that, we are in very bad trouble.

DR. PELLEGRINO: I couldn't agree more, Tom. I think that we have helped to raise those expectations, and now, when they exceed any possible capacity of ours to meet them, we want to retreat. We must enter into a more realistic dialogue with those who make policies, to indicate that there are limitations on what medicine can and cannot do. If we do that, we must first face up to whether or not we are fulfilling the expectations society has of us when it supports our endeavors.

DR. LOCKHART B. MCGUIRE (Charlottesville): In some situations there is a conflict of interests between the interests of the student, of society and of the patient. Is there a general rule that allows a priority order which the managers of medical schools or University Hospitals should regard? What is the order of priority of the interests of those three constituencies?

DR. PELLEGRINO: This is precisely the kind of question we should be looking at much more critically. I could give you my own answer. But, my purpose in raising these questions is not to tell you what I think. However, I will say this: in the circumstances in which the patient's needs for care and the student's need for teaching come into conflict, there is no question in my mind that the patient's rights supervene over both the rights of the students and the house staff to learn. To learn at the bedside is a privilege, accorded to all of us and to society by the patients in our institutions. But, when a patient participates in the teaching process, we must recognize there is an unavoidable intrusion upon his fundamental rights. Society permits this to assure a constant supply of competent new practitioners. The privilege must be guarded very, very carefully. Your question is a very appropriate one, very critical.

DR. THOMAS MCP. BROWN (Arlington, Va.): I wonder if the discussion should not be levelled at the question of the medical ethics of double-blind controls. This issue is being ignored for some reason. Apparently in England there is no legal problem under the socialized system in feigning treatment through placebos. But in our country this question could now become embarrassing, legally. We observe a host of studies coming from England that are very well controlled by double-blind methodology. On the other hand, could we not adapt new statistical principles and gain as much information evaluating covariants comparing patient clusters the way the practitioner really operates in medicine. He obtains feedback information in terms of comparative response of patients to certain treatment methods. Comparing clusters of patients treated by one method with those treated by another would circumvent the legal problem and, in addition, would usually provide more meaningful data. For the medical student following a group of placebo treated patients who are actually in need of effective medication, the ethical question of providing a poor professional example is evident. Also what about the accuracy of the double-blind method considering the necessary dropout rate in the control placebo group?

DR. PELLEGRINO: Your question is not strictly on the subject of my paper. It deals more properly with the ethics of human experimentation, and particularly randomized clinical trials. About this, there has been very extensive discussion, as you know. Charles Fried has very seriously questioned the justification for these studies and has suggested

that retrospective observational studies might do as well. (Charles Fried, *Medical Experimentation, Personal Integrity and Social Policy,* North Holland/American Elsevier, New York, 1974, p. 159).

Whether as part of his education we should expose the student to such studies, especially when placebos are used, is a question pertinent to my talk. Until the primary morality of randomized trails is better defined, the fact is that the student will be exposed. We cannot expect to protect him from reality, but rather to make him critical, reflective and inquiring about these procedures. He must as an ethically responsible professional, ultimately develop his own position, and it is the responsibility of medical schools to expose him to the techniques of ethical discourse, so that he can arrive at his viewpoint as rationally and objectively as possible.

DR. GEORGE E. SCHREINER (Washington, D.C.): There was a time historically when the only "good" education in a broad, humanistic, intellectual sense of the word existed in the traditional professions of theology, law, and medicine, and many people went to those schools. People went to theology schools that didn't intend to practice as a cleric; people went to medical school who didn't intend to practice as a doctor. I'm sure that 14,000 students in Argentina are not all going to become practicing doctors. If one looks around at the political structures of those countries, you see physician-musicians, you see physician-artists, you see physician-politicians, and so forth. This tradition has continued in other forms of education in the United States, other than medical. Your going to business school doesn't get you a job or make you an executive – if you go to accounting school, it doesn't make you a CPA. If you go to drama school, it does not make you an actor. Getting a musical education doesn't make you a musician. I wonder if a great deal of our misunderstanding that we have in the community doesn't come from the fact that the public really doesn't recognize the unique aspects of the medical school – that we really are not taking in people to teach them a humane, intellectual profession, but we're insisting that they be practitioners, so that the education becomes synonomous with the job, which doesn't happen really in any other form of education. I don't think that the average, political person really understands that. This is a truism, a simple truism that I really don't think they understand the medical business.

DR. PELLEGRINO: There are many cogent points in your comment to which I would like to respond. Dr. Wolfe says our time is up. Perhaps I can speak to you after the session.

DR. CARL MUSCHENHEIM (New York): I will make this very short, but I do want to compliment Dr. Pellegrino for bringing up these proposals of corporate introspection. It's certainly about time that someone did so. Since we are running late, I shall not take the time to elaborate on the specific areas in which medical educational values are very clearly not in the interest of the individual patients, and in which current practices not infrequently infringe upon their rights.

DR. PELLEGRINO: There are at present some very good reasons for following your suggestion of a separation between the educational and hospital functions of a medical center. But, even then, there remains the need for some additional mechanism which can coordinate both activities. Historically, in those institutions where medical school and hospital are under separate boards, conflicts of responsibility at the interface between education and research on the one hand, and patient care and community service on the other, have persisted. How can the separation which has certain advantages, be reconciled with the concurrent need for joint action, especially where decisions on one side or the other affect both sides?

DR. SMYTHE: One sort of intellectual game that I think would be worth playing, is to imagine a medical center set up like a holding company with a number of fully autonomous subsidiaries in which there were a series of services called health-care education and research, which were bought and sold one from the other. This is the way

that paper and steel companies work. I don't believe—I think that the laws of such actual reorganizations would be huge, but if one is considering organizational laws, I think that kind of borrowing is perhaps the way to dissect the problem that you raised.

DR. PELLEGRINO: That is precisely the organizational mechanism I'm establishing at the Yale-New Haven Medical Center. It does have some difficulties, as one begins to try to put in into actual operation. I hope to report on these problems and advantages at a future date.